Invoice

Rural Health Small Grants Program

Contract Number		**Billing Period (No Less Than 90 Days)**
Contractor Name		
Address		
Contract Coordinator		
Phone		
☐ **Check if Final Invoice** ☐ **Check If Final Report Submitted**		

DIRECT PATIENT CARE SERVICES (Attach back-up documentation on page 2.)

Service Description	Service Rate	Number Of Units	Service Total
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
			Subtotal $

OPERATING EXPENSES (Attach pertinent back-up documentation.)

Indirect Costs (not to exceed 10% of total budget)	Indirect Total
	$
	$
	$
	Subtotal $
Total Direct Patient Services and Operating Expenses	$
Less Advance Payment	-$
Less Amount Over Grant	$
Total Owed to Contractor	$

OSHPD Approval

_____ _____
Initials Date

Contractor's Authorized Signature/Date

_____

I CERTIFY THAT THESE ARE ACTUAL EXPENDITURES INCURRED DURING THE TIME PERIOD ABOVE AND THAT THEY COMPLY WITH ALL LAWS GOVERNING THIS PROGRAM.